WELLS FARGO FLEX BENEFIT SERVICES

381 East Broadway #110, Salt Lake City, UT 84111

Website: www.wffbs.com

Phone: (800) 473-0926 Email: flexbenefitservices@wellsfargo.com

Fax: (801) 246-3750, Toll Free Fax: (888) 824-3868

C FLEX

Employee Claim Form

REQUEST FOR REIMBURSEMENT

Company Name	Employee Social Security Number
Employee Last Name First Name M.I.	Daytime Telephone Number
Employee Street Address ○ Address Change	City, State, Zip

W.F.F.B.S. policy requires that this form be filled out completely (see form instructions). Incomplete and undocumented claims **will not** be processed.

Health Care Reimbursement Account

Date Expense Incurred (Month / Day / Year)	Patient Name	Name of Service Provider	Expense Description	Amount
				$, .
				$, .
				$, .
				$, .
				$, .
				$, .

○ **Additional Claim Forms are attached.** **TOTAL** $, .

Day Care Reimbursement Account

Date Expense Incurred (Month / Day / Year)	Name of Service Provider	Tax ID # / Social Security #	Amount
FROM TO			$, .
FROM TO			$, .

○ **Additional Claim Forms are attached.** **TOTAL** $, .

I request reimbursement for the expenses listed above. I am including receipts or other appropriate third party proof that I incurred these expenses during the plan year and during a period while the undersigned was covered under this plan. I have not been reimbursed for these expenses under our insurance plan or under any other source.

In addition, the total amount claimed for day care does not exceed the lesser of my or my spouse's expected income for the year. (Special maximums and conditions may apply if your spouse is a student or is handicapped and has no other income.)

I understand that I cannot claim these same expenses on my personal tax return since I have already received a tax advantage on these amounts via the Section 125 Plan.

Employee Signature **Date Submitted**

Instructions:

1. Complete the Employee Information Section.

2. Complete the Health Care section and/or Day Care section as appropriate. If all entries will not fit on one form, complete and submit an additional form(s) as necessary.

3. **Attach supporting documentation** as described below.

A. **Explanation of Benefits From (EOB):** This is the form you receive each time you or a health care provider submits claims for payment to your medical, dental, or other health care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) medical, dental, or other health care plans, you **must** attach an EOB.

B. **All Other Health Care Expenses:** For expenses not covered at all by your (or your spouse's) medical, dental, or other health care plans, reimbursement requests **will not be processed** without acceptable evidence of your expenses. Acceptable evidence includes itemized statements that contain the following information:

1) Actual date(s) expense was incurred*
2) Name of person for whom the service/supply was provided
3) Person or organization providing the service/supply
4) Description of service or supply
5) Cost (Note: taxes are not a reimbursable expense.)

C. **Day Care Expenses:** Please attach a receipt, (or a signed, itemized statement), that includes:

1) Actual date (From and To) of service*
2) Name, address, and Tax ID or SSN of the provider
3) Cost
4) Dependent(s) name who received the care.

* Only expenses incurred during the current year are eligible for reimbursement.

4. **Sign** and date the form.

5. **Mail, Fax, or Email the completed, signed form and attachments** to the address, fax number, or email address on the front of the form. An incomplete form, missing signature or missing attachments may result in delayed processing or claim denial.

6. If you have questions regarding your reimbursement account or claims, please call customer service at 1-800-473-0926.